Print Form

Queensland Government

Oral Health Service
Metro North Hospital and Health Services

PARENTAL CONSENT & MEDICAL / DENTAL HISTORY

Clinic Address

Clinic Name:
Address:
Phone (main):
Fax:

Please complete all details about your child and return this form to the school or school dental clinic by:

(Late replies will be accepted but treatment may be offered at another facility / location)

Details of your child

Last name: Title:
First name(s):
Alternate or previous name/s known by *(if applicable)*:
Date of birth: Gender: ☐ Male ☐ Female ☐ Indeterminate
Home address: Phone (home):
Phone (work):
Phone (mobile):
Postal address:
Contact person in case of emergency:
daphn Phone:
Medicare Number: Line No: Exp Date: /
Healthcare Card *(if applicable)* Exp Date: /
Is your child eligible for dental treatment under the Child Dental Benefits? ☐ Yes ☐ No ☐ Unsure
School attended: Grade:

If your child is eligible for the Child Dental Benefits Schedule (or if you are unsure) please complete the Bulk Billing Patient Consent form on the last page.

Consent to examination and preventative oral care

I consent to my child receiving the following:

* a dental examination, and
* dental x-rays, if considered necessary as part of the examination, and
* preventive oral care if considered necessary, such as oral hygiene assistance, cleaning of teeth and the application of fluoride to the teeth.

I understand that a parent/legal guardian must attend the examination appointment.

I understand that if my child requires further dental treatment, a parent/legal guardian will be required to sign for the proposed treatment plan before it can proceed. A parent/legal guardian or responsible adult will be required to attend further appointments for children less than 15 years of age.

I understand that if my child is eligible for treatment under the Child Dental Benefits Schedule, I will be bulk billed for any treatment and must also complete the Child Dental Benefits Schedule Bulk Billing Patient Consent Form on page 4. **There will be no charge for treatment provided.**

☐ **Yes, I consent** ☐ **No, I do not consent**

Signed (Parent/Guardian): ..... Date:

Your name:

If you have ticked "YES" to your child receiving a dental examination and preventative oral care, please complete the questionnaire overleaf.

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Please answer the following questions

Is your child of Aboriginal or Torres Strait Islander or South Sea Islander origin? *(please tick ONE box)*

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander

In which country was your child born?

☐ Australia ☐ Another country Name of the country:

What language is spoken at home? Do you require an interpreter? ☐ Yes ☐ No

Who is your child's usual medical practitioner? *(Name/address)*

Phone:

Is this child in the custody of the Department of Child Safety? ☐ Yes ☐ No

If yes, Department of Child Safety Branch Details:

Phone:

I consent to health professionals who have treated my child exchanging information about my child as may be required to assist in providing oral health care to my child. I also consent to information that has been collected by Queensland Health, when providing oral health care to my child, being used by Queensland Health to check and assess the oral health services my child has received and how those services have been used, so long as my child's name is not used in any reports or published statistics.

Signed (Parent/Guardian): ..... Date:

Dental history

Has your child been treated previously at a school dental clinic in Queensland? If YES, please give the name of the school where your child was last treated, and the year when he or she left: ☐ Yes ☐ No

School: Year:

Is your child receiving treatment from another dentist? If YES, please give details: ☐ Yes ☐ No

Is your child attending an orthodontist/dental specialist? If YES, please give details: ☐ Yes ☐ No

Please list any problems that your child has with his/her teeth or mouth:

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Medical history

☐ I have confidential medical information about my child that I do not wish to write down. I would prefer to speak to a dentist about this. *(please tick box)*

Does he/she have, or has he/she ever had, any of the following medical conditions?

Rheumatic fever	☐ Yes	☐ No	High or low blood pressure	☐ Yes	☐ No	Bronchitis or other lung diseases	☐ Yes	☐ No
Heart complaint	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart valve disorder	☐ Yes	☐ No	Contact with HIV/AIDS virus	☐ Yes	☐ No	Stomach or digestive condition	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No	Growth disorder	☐ Yes	☐ No	Nervous condition, eg. ADD	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Prosthetic or other implant	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Anaemia, leukaemia or other blood diseases	☐ Yes	☐ No	Steriod therapy	☐ Yes	☐ No	Hepatitis or other liver disease	☐ Yes	☐ No
Excessive bleeding	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Any other condition(s) Please list below	☐ Yes	☐ No

Other condition(s) not listed above:

			Details
Is your child being treated by a doctor at present?	☐ Yes	☐ No	
Is your child taking any tablets or medicines (prescribed or over-the-counter) at present?	☐ Yes	☐ No	
Does your child normally require antibiotic cover before dental treatment?	☐ Yes	☐ No	
Does your child have any abnormal reactions to local or general anaesthesia?	☐ Yes	☐ No	
Does your child smoke?	☐ Yes	☐ No	
Is your child pregnant? (Females only)	☐ Yes	☐ No	

Please list any drugs or medications your child is allergic to:

Please list any other know allergies that your child has (including latex):

Help us to connect with you - please tick the boxes, below so we know the best way to contact you:

☐ I give consent to be contacted by text (SMS) on mobile number:

☐ I give consent to be contacted by email at this email address:

** If we do not have your permission to contact you by text message (SMS) or email, we will send an appointment to your home address listed on page 1. If you change your mind in the future and wish to opt out of email or text message (SMS) notifications, please contact your treating clinic.*

Please contact your clinic if you are unable to keep any dental appointments

"Office use only: Checked by Clinician: Print name of Clinician and date:

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CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

(for services provided in a Queensland Health public sector dental clinic)

I, the **patient / legal guardian**, certify that I have been informed:

* of the treatment that has been or will be provided from this date under the Child Dental Benefits Schedule;
* of the likely cost of this treatment; and
* that I will be bulk billed for services under the Child Dental Benefits Schedule and I will not pay out-of-pocket costs for these services subject to sufficient funds being available under the benefit cap. Once my benefit cap has been reached I will not need to pay any out-of-pocket costs provided I am eligible for services in a Queensland public dental health clinic.

I understand that I / the patient will only have access to dental benefits of up to the benefit cap.

I understand that benefits for some services may have restrictions and that Child Dental Benefits Schedule covers a limited range of services. I understand I will need to personally meet the costs of any services not covered by the Child Dental Benefits Schedule or Queensland Public Dental Services.

I understand that the costs of services will reduce the available benefit cap and that I will need to personally meet the costs of any additional services not covered by Queensland Public Dental Services once benefits are exhausted.

Medicare Number: Line No: Exp Date: /

Child's name:

Last name:

First name(s):

Signed (Patient/Parent/Guardian): ..... Date:

Full name of person signing *(if not the patient)*:

This form is valid up to 31 December of the calendar year for which it is signed.

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